

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003357

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED JAN 30 1962

1. PLACE OF DEATH

a. COUNTY

ST FRANCOIS

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

BONNE TERRE MO.

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

BONNE TERRE HOSP.

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

MISSOURI ST FRANCOIS

c. CITY
OR TOWN

FARMINGTON

Inside Limits
Yes ☒ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

PARKHURST

LOWRANCE

HUNT

4. DATE
OF DEATH

Month

Day

Year

JAN.

26

1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

2/26/84

9. AGE (last birthday)

77

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BRICK MASON

10b. KIND OF BUSINESS OR INDUSTRY

BRICK MASON

11. BIRTHPLACE (City and state or country)

FARMINGTON MO.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

GILES HUNT

13b. MOTHER'S MAIDEN NAME

ANN LOWRANCE

14. NAME OF HUSBAND OR WIFE

RUTH SHICK HUNT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Ruth Hunt Farmington Mo.

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH
6 weeks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Cerebral Arteriosclerosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

1955

to Jan 25 62

and last saw him alive on Jan 20 - 62

Death occurred at

1

p

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. OCCUPATION

(Degree or title)

M. Karakevich MD

22b. ADDRESS

Farmington, Mo

22c. DATE SIGNED

1-27-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

1/28/62

23c. NAME OF CEMETERY OR CREMATORY

HILLVIEW MEMORIAL

23d. LOCATION (City, town, or county)

FARMINGTON MO.

(State)

24. FUNERAL DIRECTOR

ADDRESS

C.H.COZEAN FARMINGTON MO.

GARDENS

25. DATE RECD. BY LOCAL REG.

Jan 27, 1962

26. REGISTRAR'S SIGNATURE

Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

FEB 5 1962

MAR 15 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4084

P. O. Address Farmington N.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.